REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

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PRIVACY ACT STATEMENT AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397. PRINCIPAL PURPOSES(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members for the Armed Forces. ROUTINE USE(S): None. DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

sta	a or both) to anyone maki	ing a false statement. If v	ou are select	ed for e	 Federal law provides severe penalties (up to 5 years continemer stment, commission, or entrance into a commissioning program by ve board for discharge and could receive a less than honorable dis 	ised on a fa	lse		
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)					2. SOCIAL SECURITY NUMBER 3. TODAY'S DATE (YYYYMMDD)				
	a. HOME ADDRESS (Street		ate, ZIP Code,	, "	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)				
	b. HOME TELEPHONE (In	ciude Area Code)							
Х	ALL APPLICABLE BOXES				7.a. POSITION (Title, 0	arade, Compo	onent)		
6.	a. SERVICE	b. COMPONENT	c. PURPO	SE OF E	AMINATION CIVILIAN				
	Army Coast Guard	Active Duty	Enlistr	ment	Medical Board Other (Specify) b. USUAL OCCUPA	TION			
	Navy	Reserve	Comn	nission	Retirement				
	Marine Corps	National Guard	Reten	tion	U.S. Service Academy				
	Air Force		Separ	ation	ROTC Scholarship Program				
_	CURRENT MEDICATION	C (Barranistian and Over th		ation	9. ALLERGIES (Including insect bites/stings, foods, medicine or other	substancel			
	rk each item "YES" or "N								
						VEO	110		
H	AVE YOU EVER HAD OR	DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO		
	a. Tuberculosis		YES	0	f. Foot trouble (e.g., pain, corns, bunions, etc.)	0	0		
10.	a. Tuberculosisb. Lived with someone who			0	f. Foot trouble (e.g., pain, corns, bunions, etc.) g. Impaired use of arms, legs, hands, or feet	0	0		
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111.	a. Tuberculosis b. Lived with someone who c. Coughed up blood d. Asthma or any breathing weather, pollens, etc. e. Shortness of breath f. Bronchitis g. Wheezing or problems w h. Been prescribed or used i. A chronic cough or cougl j. Sinusitis k. Hay fever l. Chronic or frequent colds a. Severe tooth or gum trou b. Thyroid trouble or goiter c. Eye disorder or trouble d. Ear, nose, or throat troub e. Loss of vision in either er f. Worn contact lenses or g g. A hearing loss or wear a h. Surgery to correct vision a. Painful shoulder, elbow o b. Arthritis, rheumatism, or	p had tuberculosis problems related to exercis ith wheezing an inhaler h at night suble ple ye glasses hearing aid (RK, PRK, LASIK, etc.) pr wrist (e.g. pain, dislocation bursitis	O O O O O O O O O O O O O O O O O O O	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	f. Foot trouble (e.g., pain, corns, bunions, etc.) g. Impaired use of arms, legs, hands, or feet h. Swollen or painful joint(s) i. Knee trouble (e.g., locking, giving out, pain or ligament injury, j. Any knee or foot surgery including arthroscopy or the use of scope to any bone or joint k. Any need to use corrective devices such as prosthetic device knee brace(s), back support(s), lifts or orthotics, etc. l. Bone, joint, or other deformity m. Plate(s), screw(s), rod(s) or pin(s) in any bone n. Broken bone(s) (cracked or fractured) 13. a. Frequent indigestion or heartburn b. Stomach, liver, intestinal trouble, or ulcer c. Gall bladder trouble or gallstones d. Jaundice or hepatitis (liver disease) e. Rupture/hernia f. Rectal disease, hemorrhoids or blood from the rectum g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) h. Frequent or painful urination i. High or low blood sugar j. Kidney stone or blood in urine k. Sugar or protein in urine l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	O O O O O O O O O O O O O O O O O O O	000000000000000000000000000000000000000		

LAST	NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURIT	TNU	MBEK				
Mark	each item "YES" or "NO".			Mark each item "YES" or "NO". For Items 19 - 28, every item marked "YES" must be fully explained in Item 29 below.				
HAVE	YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	НА	VE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	
15. a.	Dizziness or fainting spells	<u> </u>	0	19	. Have you been refused employment or been unable to hold a job or			
	Frequent or severe headache	<u>Q</u>	-9	H	stay in school because of:			
	A head injury, memory loss or amnesia		$ \bigcirc$	١H	a. Sensitivity to chemicals, dust, sunlight, etc.			
	Paralysis	<u> </u>	$ \stackrel{\bigcirc}{\sim}$		b. Inability to perform certain motions	\forall	\sim	
	Seizures, convulsions, epilepsy or fits	$-\frac{\circ}{\circ}$		\vdash	c. Inability to stand, sit, kneel, lie down, etc.	\preceq	- >	
	Car, train, sea, or air sickness		- 6	 	d. Other medical reasons (If yes, give reasons.)			
	A period of unconsciousness or concussion Meningitis, encephalitis, or other neurological problems	$-\frac{\circ}{\circ}$	$\stackrel{\sim}{\sim}$	20). Have you ever been treated in an Emergency Room? (If yes, for what?)	\circ	\circ	
h. 16 a	Rheumatic fever	$\frac{\beta}{\beta}$	0	11				
	Prolonged bleeding (as after an injury or tooth extraction, et	c.) (ŏ	21	. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete	\bigcirc	\circ	
_	Pain or pressure in the chest	ŏ	Ö		address of hospital.)		****	
d.	Palpitation, pounding heart or abnormal heartbeat	Ö	0	22	. Have you ever had, or have you been advised to have any			
e.	Heart trouble or murmur] ''	operations or surgery? (If yes, describe and give age at which	\circ	\bigcirc	
f.	High or low blood pressure		\circ		occurred.)			
17. a.	Nervous trouble of any sort (anxiety or panic attacks)	0		23	B. Have you ever had any illness or injury other than those	\bigcirc	\cap	
b.		<u> </u>	_ Q_		already noted? (If yes, specify when, where, and give details.)	\sim	<u> </u>	
C.	Loss of memory or amnesia, or neurological symptoms	<u>Q</u>	<u> </u>	24	. Have you consulted or been treated by clinics, physicians,			
d.	Frequent trouble sleeping	<u> </u>		11	healers, or other practitioners within the past 5 years for	\bigcirc	\circ	
е.	Received counseling of any type	Q	Q		other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)			
f.	Depression or excessive worry	<u> </u>	-Q	┨┣━	of doctor, heapitary chinic, and doctarery			
9	Been evaluated or treated for a mental condition (If yes, fully explain in Item 29 below.)	()	<u> </u>	25	. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	0	\circ	
	Attempted suicide		-2 $-$	26	6. Have you ever been discharged from military service for any reason?			
i.				- 1	(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	\circ	()	
18.		e:		┨┝				
	Treatment for a gynecological (female) disorder	-8	$ \approx$	27	Have you ever received, is there pending, or have you ever	,	~	
	A change of menstrual pattern		$ \stackrel{\sim}{\sim}$	11	applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount,	\circ	()	
	Any abnormal PAP smears First day of last menstrual period (YYYYMMDD).	💭 .			when, why.)			
<u> </u>	Date of last PAP smear (YYYYMM).			1 7	B. Have you ever been denied life insurance?	\cap	\bigcirc	
	OTE: HAND TO THE DOCTOR OR NITRSE OR IF M	AH ED	MARK	-NVFI	OPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."			

GUESTIONING REVEALS VES NO DETAILS MARQUANA USE OTHER DRUG ABUSE ALCOHOL ABUSE EXAMINEE. I carrify the information on this form is true and complete to the best of my knowledge and ballef, and no person has advised me to conceal or faisify any information about my drivate land mental history. I further understand that I say be regulated to provide medical documentation repringing lauses within my model information about my drivate land mental history. I further understand that I say be requested to provide medical aboutmentation repringing lauses within medical about my drivate medical and mental history. I further understand that I say be requested to provide medical aboutmentation and the same medical about my drivate medical and mental history. I further understand that I say to remark the complete transcript of any medical about my drivate medical and mental history. I further understand that I say to remark the complete transcript of any medical about my drivate medical and mental history. I further understand that I say be requested to provide medical about my drivate medical and mental history. I further understand that I say be requested to provide medical about my drivate medical and mental history. I further understand that I say be requested to provide medical about my drivate medical and mental history. I further understand that I say be requested to the provide medical and mental history. EXAMINEE SIGNATURE EXAMINEE SIGNATURE DATE DATE G. SIGNATURE G. SIGNATURE OTHER SIGNATURE	LAST NAME, FIRST NA	ME, M	IIDDLE	NAME (SUFFIX)				SOCIAL S	ECURITY NUMBER
QUESTIONING REVEALS VES NO DETAILS MARQUANA USE OTHER DRUG ABUSE EXAMINEE: Seaffly the information on this form is true and complete to the best of my knowledge and belief, and an person has advised me to conceed or failily any information about my physical and mental history. Fluther understand that I may be requested to povide medical decommendation regarding issues within my medical medical record for purposes of processing my applications for military service, and in truth the beginners of Declarace studied arthority a complete medical record for purposes of processing my application for military service, and the processing my application for military service. But the processing my application for military service, and the processing my application for military service. EXAMINEE SIGNATURE DATE DA	30.EXAMINER'S SUMN	IARY A	AND EL	ABORATION OF Al	LL PERTINEN	T DATA (Physician/pra al history deemed impoi	ectitioner shall comment on tant, and record any signif	all positive answers icant findings here.	in questions 8 - 29.
MARIJUANA USE OTHER DRUG ABUSE ALCOHOL ABUSE EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service. EXAMINEE SIGNATURE DATE		t may d	levelop	by interview any add	itional medica	al history deemed impor	tant, and record any signif	icant findings here.	
EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service. EXAMINEE SIGNATURE DATE DATE DATE DATE DATE DATE DATE D. DATE SIGNATURE D. DATE SIGNATURE D. DATE SIGNATURE		YES	NO	DETAILS					
EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service. EXAMINEE SIGNATURE DATE DATE DATE DATE DATE DATE DATE	OTHER DRUG ABUSE								
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b TYPED OR PRINTED NAME OF EXAMINER C. SIGNATURE d. DATE SIGNED	information about my ph	ysical a	ınd men octors. h	tal history. I further u nospitals, clinics or ins	ınderstand tha: urance compar	t I may be requested to p ny(ies) to furnish the Depa	rovide medical documentation artment of Defense medical a	n regarding issues Wi authority a complete 1	tnin my medical transcript of my
(YYYYMMDD)	b. TYPED OR PRINTE	D NAM	E OF EX	CAMINER	c. s	SIGNATURE	EXAMINEE SIGNATUR	RE	d. DATE SIGNED
DoD exception to SF 93 approved by ICMR, August 3, 2000. Page 3 of 4 Pages	J. THED OR FRINTE	- IVINI	- 01 -						(YYYYMMDD)

AST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
1. ADDITIONAL REMARKS. (Extention of blocks 29 or 30).	 AND PARTY.